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Context, culture and beyond: medical oaths in a globalising world

Esther Helmich¹  & Marco Antonio de Carvalho-Filho² 

Medical oaths reflect the ethical principles that physicians and society believe are essential to clinical practice. In some countries, being awarded a medical degree even depends on this public commitment: to become a physician, the young apprentice must vow fidelity to a set of core professional values. Being aware of those values has become even more important now as medical educators start to recognise the importance of professional identity formation as

a dominant goal of medical education.¹ We therefore commend Greiner and Kaldjian for their paper reporting a content analysis of medical oaths taken in the USA and Canada,² published in this issue of *Medical Education*. However, we do ask ourselves why the authors² restricted their study to North America, and how we should interpret the observed plurality of medical oaths. In this commentary, we want to address three issues:

- 1 Do we need an oath as a (universal) rite of passage?
- 2 Do we have universal values, or are these instead regional, local or otherwise contextualised?
- 3 Do the words we use for those values have the same meanings in different parts of the world?

Oath taking is not a universal endeavour. A recent survey amongst members of the World Medical Association revealed that in only half of responding countries does a mandatory oath for physicians exist; 30% of the countries surveyed use some kind of voluntary oath and around 20% use no medical oath at all.³ The prevalence of oath taking

varies globally from a full 100% of medical students in the Netherlands and Brazil to, for instance, 50–70% in the UK⁴ and close to zero in many African countries.⁵ In addition, not only does the content of medical oaths vary considerably across medical schools in the USA and Canada, as Greiner and Kaldjian² describe, but it also does so within other countries and around the world.⁶

Oath taking is not a universal endeavour

Oaths originate from a certain social contract between the profession and society. Regardless of their moral foundation, traditionally oaths are the result of a social process conducted under the influences of philosophical, religious, political and even economic forces, and as such do not simply represent a personal endeavour.⁷ In different periods of history, oaths were intentionally used to provide resistance against the undermining of the main values of the medical profession, and we imagine that oaths may have the same power in current times. Building on a long

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Hippocratic tradition, Western medical codes regained explicit attention after World War II in response to the unethical conduct of doctors under the Nazi regime. It is now over 70 years since the world witnessed the Nuremberg Doctors Trial in 1947, which led to the formulation of strict research ethics rules to protect patients, known as the Nuremberg Code. The following year, 1948, saw the adoption of the Declaration of Geneva, which, after a recent update, will now celebrate its 70th anniversary.

Oaths originate from a certain social contract between the profession and society

This Declaration of Geneva is based on the original Hippocratic Oath, which, at the time, was thoroughly edited and adapted.³ To meet the demands of a changing society, the Declaration of Geneva has been amended or revised several times, with a last revision in 2017. As the oath is a symbol representing the social contract of physicians with society, we feel concerned about the development of new oaths that are based solely on local or individual needs, as described by Greiner and Kaldjian.² We do realise that the oath needs to reflect ongoing societal developments; for instance in the Netherlands, the reference to protecting life has been altered following changes in legislation with regard to abortion and euthanasia.¹ However, while we appreciate the need for adaptation and modernisation, we think the medical profession should be careful about replacing this robust and ancient symbol, which still reflects certain core values: the individualising of medical oaths may imply to

students that they can freely choose the social contract they want to follow.

Oaths are the result of a social process conducted under the influences of philosophical, religious, political and economic forces

Core professional values and conceptions of what constitutes good behaviour may be interpreted, emphasised or expressed differently in various cultures.¹ The notion of accountability, for instance, can be understood as something individual, but also as being relational, social or even divine, depending on culture or society.¹ Moreover, the contexts in which doctors care for patients differ greatly around the world. Physicians working under authoritarian regimes or in situations of political conflict or war will face challenges that differ greatly from those that confront their colleagues in safe and democratic countries. How do we prioritise autonomy in a refugee camp or in a war zone? What does non-maleficence mean in such a context? Doctors who care for patients in non-egalitarian societies with large socio-economic differences and limited resources face different professional dilemmas to their colleagues in rich and affluent countries. In countries in which the health system is unequal in its coverage, there are daily conflicts between beneficence and equity. Different societies thus may not only interpret values differently, but they may also expect different behaviours from physicians: if values and contexts vary, the wisest decision – in terms of the best course of action – will also differ amongst societies.

Conceptions of what constitutes good behaviour may be interpreted, emphasised or expressed differently in various cultures

The oldest references to the social contract of the medical profession attest to the importance of beneficence, altruism, confidentiality and non-maleficence. Progressively, medical morality adopted autonomy and subsequently social justice as equally important values. These words, however, may not carry the same meanings in different cultural contexts. Social justice is certainly conceived differently across a dictatorship, a democracy, a theocracy and a caste-based society. A seemingly universal concept, such as autonomy, may be understood differently in different parts of the world.⁸

A seemingly universal concept, such as autonomy, may be understood differently in different parts of the world

Emphasising the importance of the Hippocratic Oath, while appreciating that similar significant professional documents reflecting important ethical values have been ascribed to Buddhist, Hindu, Confucian and Islamic medical traditions,⁹ we think that the still-dominant Western discourses around medical ethics and professional values should be broadened to include and learn from other perspectives. Therefore, we would like to advocate for the introduction of standard companion pieces: when a highly context-specific paper such as that by Greiner and Kaldjian² is published, we hope that journals such as *Medical Education* will continue to invite medical educators from different parts of the world to write commentaries or

companion papers on the same topic from different perspectives in order to open up the dominant Western gaze in search of context.

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Silence is golden

Georga Cooke  & Ben Mitchell

Hesitation has something of a bad name in clinical practice. Ott et al.¹ highlight some of the automatic thoughts and judgements that surgeons and their trainees have and make when they experience hesitations and pauses during surgical procedures. They outline these because progress is highly valued in the surgical profession; hesitation during a surgical procedure is viewed not simply as somewhat time-inefficient, but as a sign of incompetence.

However, in other contexts, hesitation can be valued. Indeed, in other settings, the word 'hesitation' may be replaced with a more neutral or positive construct, such as 'deliberation', 'pause', 'reflection' or 'timeout'. A pause, for example during handwashing after a physical examination, may be a deliberate strategy that a clinician uses to structure thinking time into a clinical interaction.² Huang et al. conducted a pilot study of a structured diagnostic pause after a consultation in an ambulatory care setting.³ Although only a minority of cases resulted in a change of approach, the study opened up possibilities for more integrated approaches to diagnostic pauses.³

In our own clinical experience, these diagnostic pauses may also be unconscious, such as when we have found ourselves listening a little longer than strictly necessary to a chest. Hesitations and pauses can also have therapeutic purposes: they may represent a means to convey empathy or an invitation for the patient to take the time he or she needs to digest the conversation;⁴ or a means to ensure patient safety, such as in surgical time out.

A pause... may be a deliberate strategy that a clinician uses to structure thinking time into a clinical interaction

Hesitation may be replaced with a more neutral or positive construct, such as 'deliberation', 'pause', 'reflection' or 'timeout'

Another interesting theme emerged in this study in that some participants described experiencing resident hesitation as a 'game of chicken', with both learner and supervisor hesitating together. When it comes to the

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